

Case Report

**MEDICALLY UNEXPLAINED SYMPTOMS EXPLAINED!!!! A CASE OF
POST ORGASMIC ILLNESS SYNDROME**

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ABSTRACT

Medically unexplained symptoms are often the common reason for consultation. They are a challenge to the treating physician and end up being labeled as psychological. We report a case of medically unexplained symptoms associated with sexual orgasm and the possible syndrome.

Key Words: *Medically Unexplained Symptom, Post Orgasm, Illness Behavior, Psychometry*

INTRODUCTION

Bodily symptoms are often the commonest reason for seeking medical consultations. Many a times the cause is not evident or not explained by any illness model it may be referred or treated as a psychological condition. The common symptoms are bodily pain, fatigue and non specific sensory symptoms. Patients have various models and associations for their symptoms and their explanations are confounded by their interactions with health professionals. Bodily symptoms associated predominantly with sexual activity are rarely reported. A bodily symptom like tiredness, aches linked to loss semen has been described as dhat syndrome. These conditions can cause significant distress to the person and also can lead to frustrations in the treating physician. We report a case of patient who presented with somatic symptoms related to orgasm. Written consent was provided by the patient during registration.

CASES

Mr A, a 35 year old married man from lower socioeconomic status and rural background, literate, presented to us with complaints of uneasy feeling in thighs, legs, lower back and whole body ache since four years. He also reported that he has been feeling feverish and tiredness after any minimal effort. He reported that he has noticed these symptoms after having sexual intercourse with his wife. He reported that these fluey symptoms started gradually after the sexual intercourse and peaked in one to two days. For these symptoms he has consulted a physician who requested for blood investigations to rule out typhoid. Patient had nonspecific findings on widal and was treated with antibiotics for a week. He felt better. These symptoms have since then been noticed to occur following sexual intercourse. He reports that if he abstains from sexual intercourse he does not experience these symptoms. However, the symptoms did not prevent him from sexual activity, which he continued despite the distress. He has been married for fifteen years and did not experience any sexual problems till four years ago. He does not report any change in his sexual desire, nor report any sexual difficulties, ejaculation or erection problems. The wife did not report any sexual problems in the patient or herself, and reported no change in the pattern of sexual activity. He also reported of experiencing pleasure during sexual activity. He continued to be sexually active since four years. He has been visiting various physicians for the above reported symptoms and has undergone repeated blood investigations to rule out typhoid fever.

He also reports of having significant stressors at his work and reports feeling sad, low energy and poor sleep since two years. He has made a deliberate self harm attempt in the last year by consuming organophosphours pesticide and was treated for the same. There was no significant past or family history. There was no history of any substance abuse or high risk sexual behavior. However, premorbidly he was

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known to be an introvert and anxious person and was very concerned about his health. The family had been consulting multiple physicians and hospitals for his treatment and did not see any improvement. On general physical examination no abnormality was detected. On mental status examination patient appeared tense, had preoccupation about his bodily symptoms, depressive cognitions and depressed affect.

Since the patient had long standing complaints with multiple consultations and poor response, review of history and diagnosis was sought. Psychological assessment(using Rorschach inkblot test & Thematic apperception test) revealed preoccupation with sexual content ; rejection of sex card; conflict with spouse/contemplating separation by wife ; uncertainty about future ;inadequate coping behaviors ; dysphoric expression in form of helplessness and hopelessness indicative of depression. Patient had been having various consultations and believed whether he had typhoid or any other physical health problems despite investigations being normal. Hence illness behavior assessment was done. Illness behavior questionnaire (IBQ) was administered. The IBQ scores indicated high levels of general hypochondriasis (6/9), disease conviction (6/6), high scores on affective distress, irritability and affective inhibition. There was high level of denial of significant stressors. Urologist opinion was also ought to rule out any other urogenital pathology which was normal. Since the patient significant bodily symptoms which were suggestive of flu like symptoms linked to the sexual intercourse a possibility of postorgasmic illness syndrome was considered. There is very little evidence on its treatment and hence symptomatic treatment was suggested. The patient had no features of dhat syndrome.

Since this patient demonstrated significant levels of affective symptoms and anxiety, fatigue, a low dose Amitriptyline was prescribed along with Jacobson's progressive muscular relaxation was done. He was prescribed Salbutamine [Arcalion] for symptomatic relief from fatigue. Patient was educated about this condition and was much relieved after the psychoeducation.

DISCUSSION

Medically unexplained symptoms are described as those not explained by the routine and special investigations as in this case. However in this case clinical evaluation showed post orgasmic illness syndrome features. Postorgasmic illness syndrome was first described by Waldinger et al in 2002 in two patients who had flulike symptoms following ejaculation which lasted for four to seven days. They postulated that there could be a possible autoimmune etiology rather than it being psychological or hypochondriasis. In the subsequent studies done by Waldinger *et al.*, (2011 a and b) tested autoimmune hypothesis in forty five male subjects with postorgasmic illness syndrome and reported that it is possible immune related phenomenon and also treatment by hyposensitisation with their own semen. This case highlights the fact that there are patients who present with somatic symptoms may actually suffer from a syndrome. Often patient with chemical sensitivity syndromes are clubbed are treated as somatoform disorders or medically unexplained symptom. This can result in over investigation and inappropriate treatments. Our case also indicates abnormal illness [sexual] behavior as indicated by high scores on IBQ. Psychological assessment also revealed underlying sexual conflict with affective features; however, no such evidence was noted on clinical evaluation. Further the psychometry is providing indicators towards sexual conflicts as is also confirmed by high denial on IBQ. Patients with medically unexplained symptoms, even if these are sexual, need proper evaluation and thorough assessments. It is important to look for the possible links and interference with activities. Post orgasmic illness syndrome may be more common than expected and may be ignored by the person.

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